Report

of the

Examination of

Managed Health Services Insurance Corporation

Milwaukee, Wisconsin

As of December 31, 2001

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State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Jim Doyle, *Governor*
Jorge Gomez, *Commissioner*

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November 19, 2002

Honorable Jorge Gomez
Commissioner of Insurance
125 South Webster Street
Madison, Wisconsin 53702

Commissioner:

In accordance with your instructions, a compliance examination has been made of the affairs and financial condition of:

MANAGED HEALTH SERVICES INSURANCE CORPORATION
Milwaukee, Wisconsin

and this report is respectfully submitted.

I. INTRODUCTION

The previous examination of Managed Health Services Insurance Corporation (the HMO) was conducted in 1999 as of December 31, 1998. The current examination covered the intervening period ending December 31, 2001, and included a review of such 2000 transactions as deemed necessary to complete the examination.

The examination consisted of a review of all major phases of the HMO's operations, and included the following areas:

History
Management and Control
Corporate Records
Conflict of Interest
Fidelity Bonds and Other Insurance
Provider Contracts
Territory and Plan of Operations
Affiliated Companies
Growth of the HMO
Reinsurance
Financial Statements
Accounts and Records
Data Processing

Emphasis was placed on the audit of those areas of the HMO's operations accorded a high priority by the examiner-in-charge when planning the examination. Special attention was given to the action taken by the HMO to satisfy the recommendations and comments made in the previous examination report.

The section of this report titled "Summary of Examination Results" contains comments and elaboration on those areas where adverse findings were noted or where unusual situations existed. Comment on the remaining areas of the HMO's operations is contained in the examination work papers.

The HMO is annually audited by an independent public accounting firm as prescribed by s. Ins 50.05, Wis. Adm. Code. An integral part of this compliance examination was the review of the independent accountant's work papers. Based on the results of the review of these work papers, alternative or additional examination steps deemed necessary for the completion of this examination were performed. The examination work papers contain documentation with respect to the alternative or additional examination steps performed during the course of the examination.

II. HISTORY AND PLAN OF OPERATION

Managed Health Services Insurance Corp. (MHSIC) can be described as a for-profit mixed model health maintenance organization (HMO) insurer. An HMO insurer is defined by s. 609.01 (2), Wis. Stat., as "a health care plan offered by an organization established under ch. 185, 611, 613, or 614 or issued a certificate of authority under ch. 618, Wis. Stat. that makes available to its enrolled participants, in consideration for predetermined fixed payments, comprehensive health care services performed by providers selected by the organization." Under the mixed model, the HMO has a delivery system consisting of a combination of Independent Practice Associations (IPAs) and/or one or more clinics and/or independent contracting physicians operating out of their separate offices. HMOs compete with traditional fee-for-service health care delivery.

MHSIC was incorporated August 31, 1990, as a wholly owned subsidiary of Managed Health Services, Inc (MHSI), a Wisconsin nonstock, not-for-profit corporation. The HMO commenced business on December 17, 1990. On September 8, 1993, Coordinated Care Corporation (CCC), a Wisconsin stock corporation, acquired 100% of the outstanding common stock of MHSIC from MHSI. On November 20, 1996, the name of Coordinated Care Corporation was changed to Centene Corporation (CC).

The company has undergone several mergers since its acquisition by Coordinated Care Corporation. On September 1, 1997, MHSIC purchased Genesis Health Plan Insurance Corp. (GHPIC). The operations of MHSIC and GHPIC were merged with MHSIC as the surviving company. On October 1, 1998, MHSIC acquired Maxicare Health Insurance Company of Milwaukee. The company continued to exist as a separate company under a new name, Coordinated Care Health Plan, Inc. (CCHP) until December 31, 1999, when it was merged into MHSIC. On February 1, 2001, MHSIC purchased the Medicaid/BagerCare line of business from Humana Wisconsin Health Insurance Corporation. Approximately 23,000 Medicaid enrollees were transferred to MHSIC.

MHSIC derives all of its revenue from the Wisconsin Title XIX Medical Assistance and BadgerCare Programs. The HMO contracts directly with the Wisconsin Department of Health and Family Services (DHFS) to provide health care benefits to eligible Medical Assistance (Medicaid) recipients through its MHSIC license. In addition, the HMO provides benefits to the Medicaid enrollees of another HMO, Network Health Plan (NHP), through a subcontract. The current contract with DHFS, for all participating HMOs, will expire on December 31, 2003. The subcontract with NHP will expire on December 31, 2006.

The company began marketing a commercial product in 1992, to comply with a federal law that required HMOs to maintain a minimum 25% commercial enrollment in order to participate in the Medicaid initiative. With the enactment of the Balanced Budget Act of 1997, HMOs are no longer required to maintain a minimum commercial enrollment. MHSIC withdrew from the commercial market as of December 31, 1999.

The HMO provides primary and specialty health services to Medicaid/BadgerCare enrollees through contractual arrangements with physicians, IPAs, group practices, PHOs, and clinics. Physician services are reimbursed on either a capitated or fee schedule basis. Currently, only the Sixteenth Street Community Health Center and the Downtown Health Center are capitated for primary care and specialty physician services.

The contracts include hold-harmless provisions for the protection of policyholders, have a one-year term, and automatically renew unless terminated by either party giving written notice to the other party at least ninety days prior to the end of the initial or renewal term. In addition, the Medicaid contracts require physicians to participate in and contribute information for the company's quality improvement and utilization management programs, and abide by applicable provisions of the contract with DHFS.

The following is a list of the IPAs, group practices, PHOs, and clinics serving the Medicaid/BadgerCare enrollees:

IPAs
Affinity Medical Group
Children's Medical Group
Community Health Network
Herslof Optical (Vision)
HCMS
Holy Family Memorial, Inc.
MCW Behavioral Health (Mental Health and AODA)
Midwest Rehabilitation Network (Outpatient rehabilitation)
Physician's Health Network
St. Joseph's Physician Association
Southeast Dental Associates (Dental)
Wisconsin Area Physicians' Association
Wausau Regional Health Care

PHOs
Beloit PHO

Clinics
Aurora Medical Group
Children's Health Services
Downtown Health Center
Fond du Lac Regional Clinic
Harwood Medical Group
Howard Young Physicians
Kenosha Community Health Center
Krohn Clinic
LaSalle Clinic
Marshfield Clinic
Medical Associates
Medical College of Wisconsin
Milwaukee Health Services
Prevea
Rice Clinic
Sixteenth Street Community Health Center
Waukesha Medical Center

Inpatient services to Medicaid enrollees are provided through contracts with 51 hospitals. The hospitals are generally paid on a DRG or a per diem basis. The contracts include hold harmless provisions for the protection of policyholders, automatically renew for one-year terms, and may be terminated by either party upon 90 days' written notice prior to the next termination date of the contract between the HMO and DHFS. The following is a list of hospitals serving Medicaid/BadgerCare enrollees:

Aurora Medical Center, Kenosha, WI
Aurora Medical Center, Manitowoc County
Aurora Medical Center, Washington County
Bay Area Medical Center (Aurora), Green Bay, WI
Beaver Dam Community Hospital, Beaver Dam, WI
Beloit Memorial Hospital, Beloit, WI
Berlin Memorial Hospital, Berlin, WI
Bloomer Community Hospital, Bloomer, WI
Calumet Medical Center, Chilton, WI
Children's Hospital, Fox Valley, WI
Children's Hospital, Kenosha, WI
Children's Hospital, Milwaukee, WI
Divine Savior Hospital, Portage, WI
Eagle River Hospital, Eagle River, WI
Elmbrook Memorial Hospital, Brookfield, WI
Fort Atkinson Memorial Hospital, Fort Atkinson, WI
Holy Family Memorial Hospital, Manitowoc, WI
Howard Young Medical Center, Woodruff, WI
Lakeland Medical Center, Elkhorn, WI
Memorial Hospital of Burlington, Burlington, WI
Memorial Hospital of Oconomowoc, Oconomowoc, WI

Memorial Hospital, Neillsville, WI
Mercy Medical Center, Oshkosh, WI
New London Family Medical Center, New London, WI
Ripon Medical Center, Ripon, WI
Riverside Medical Center, Waupaca, WI
Riverview Hospital, Wisconsin Rapids, WI
Shawano Medical Center, Shawano, WI
Sheboygan Medical Center, Sheboygan, WI
Sinai Samaritan Medical Center, Milwaukee, WI
St. Agnes Hospital, Fond du Lac, WI
St. Elizabeth's Hospital, Appleton, WI
St. Francis Hospital, Milwaukee, WI
St. Joseph's Community Hospital, West Bend, WI
St. Joseph's Hospital, Milwaukee, WI
St. Joseph's Hospital-Bluemound, Milwaukee, WI
St. Joseph's Hospital-Chippewa, Chippewa Falls, WI
St. Luke's Medical Center, Milwaukee, WI
St. Luke's South Shore, Cudahy, WI
St. Mary's Hospital Medical Center, Madison, WI
St. Mary's Hospital, Green Bay, WI
St. Michael Hospital, Milwaukee, WI
St. Nicholas Hospital, Sheboygan, WI
St. Vincent Hospital, Green Bay, WI
Valley View Medical Center, Plymouth, WI
Victory Medical Center, Stanley, WI
Watertown Memorial Hospital, Watertown, WI
Waupun Memorial Hospital, Waupun, WI
West Allis Memorial Hospital, West Allis, WI
Wild Rose Community Hospital, Wild Rose, WI

The HMO's service area for Medicaid and BagerCare is comprised of the following counties: Brown, Calumet, Dodge, Fond du Lac, Green Lake, Kenosha, Manitowoc, Marathon, Milwaukee, Outagamie, Ozaukee, Racine, Rock, Sheboygan, Walworth, Washington, Waukesha, Waupaca, Waushara, Winnebago, and Wood.

Benefits for its Medicaid/BadgerCare members are provided for in the contract between MHSIC and DHFS. Coverage may be consistent with coverage specified in the State Plan; however, the HMO retains that right to determine the medical necessity of a covered service and to require prior authorization of certain services which it identifies.

The HMO has instituted various control procedures to ensure compliance with the plan. Procedures have been developed to monitor the actions of its primary care physicians. In addition, the HMO's medical director must preauthorize all elective out-of-plan referrals. Failure to preauthorize can result in nonpayment.

The HMO has instituted procedures to achieve timely resolution of grievances. All grievances are to be acknowledged within 10 days of receipt (two business days for urgent or emergent situations). If the grievance cannot be resolved internally, the grievance committee will be convened. Seven calendar days prior to the meeting, the member is informed a meeting will be held, and is invited to present the facts before the committee. If the grievance committee decision is not satisfactory to the member, the member has the right to appeal the decision to the HMO Ombudsman or the Division of Hearing and Appeals.

III. MANAGEMENT AND CONTROL

Board of Directors

The board of directors consists of eleven members. All directors are elected annually to serve a one-year term. Officers are elected by the board of directors. Members of the HMO's board of directors may also be members of other boards of directors in the holding HMO group. The board members not employed by Centene currently receive $250 per meeting for serving on the board. Employees of Centene do not receive compensation for serving on the board.

Currently the board of directors consists of the following persons:

Name and Residence	Principal Occupation
Tony Caceres, MD Milwaukee, WI	Internal Medicine Aurora Sinai Medical Center
Randy Ciepluch, DDS Milwaukee, WI	Dentist Sole Proprietor
Kathleen Crampton Lake Geneva, WI	President & CEO Managed Health Service Insurance Corp
Ricardo Diaz Milwaukee, WI	Consultant Self Employed
Walter Lanier, Esq. Milwaukee, WI	Attorney Lanier Law Offices, LTD
Cheryl Martin, MD Milwaukee, WI	Internal Medicine Sinai Samaritan Medical Center
Steven Moffic, MD Milwaukee, WI	Psychiatrist Medical College of Wisconsin
Michael Neidorff St. Louis, MO	President & CEO Centene Corporation
Gigi Pomerantz, RNC, MS, APNP Glendale, WI	Nurse Practitioner Aurora Sinai Medical Center
John Waeltz, MD Whitefish Bay, WI	OB/GYN Glenpoint OB/GYN
Karey Witty St. Louis, MO	Senior VP & CFO Centene Corporation

Board members' terms are continuous until they are replaced.

Officers of the Company

The officers elected by the board of directors and serving at the time of this examination are as follows:

Name	Office	2002 Salary
Kathleen Crampton	President & CEO	$230,000*
Michael Lynch	Medical Director	177,990*
Sandra Tunis	SVP: Program Performance and Regulatory Affairs	122,365*
Lu Alexander	VP: Medical Management	96,000*
Mina Tepper	VP: Provider & Consumer Relations	94,185*

*The officers' salaries are paid by Centene Management Corporation, a wholly owned subsidiary of Centene Corporation, through a management agreement with MHSIC.

Committees of the Board

The HMO's bylaws allow for the formation of certain committees by the board of directors. According to the bylaws, members of each committee are elected by a majority vote of the Board of Directors. Committees may consist of persons who are not Directors of the Corporation, however each committee shall include at least one member of the Board of Directors. The committees at the time of the examination are listed below.

QI/UM Peer Review Committee
Cecilia Howell-Canada, Chair
Aaron Bodner
Jane Chevako
Lawrence Howards
Kevin Izard
Bob Lyon
H. Steven Moffic
John Waeltz

Pharmacy and Therapeutics Committee
Michael Lynch, MD, Chair
Lu Alexander
Frederik Broekhuizen
Cecilia Howell-Canada
Guy Lord
H. Steven Moffic
John Pacey
Lori Polzin
Naomi Prieto
Lynn Radmer
Patricia Safavi
C.M.M. Sundaram
Alejandro Vinluan
Masood Wasiullah

Quality Improvement Council
Michael Lynch, MD, Chair
Tony Caceres
Randy Ciepluch
Kathleen Crampton
Ricardo Diaz
Walter Lanier
Cheryl Martin
Steven Moffic
Gigi Pomerantz
Naomi Prieto
John Waeltz
Lu Alexander
Kathleen Crampton
Katrina Jenkins
Jan Larson
Mina Tepper
Sandi Tunis
Jennifer Winter

Credentialing Oversight Committee
Kathleen Crampton, Chair
Jan Larson
Michael Lynch, MD

The HMO has no employees. Staff is provided through a management agreement with Centene Management Corporation (CMC), a wholly owned subsidiary of Centene Corporation. Under the January 1, 1997 agreement, CMC agrees to provide MHSIC with administrative and financial services necessary to manage the business operations of the HMO, and agrees to assume responsibility for all costs associated therewith. Areas/systems for which CMC assumes responsibility, under the terms of the agreement, include the following: program planning and development, management information systems, financial systems and services, claims administration, provider and enrollee services and records, utilization and peer review, quality assurance/quality improvement, and marketing services. CMC receives a management fee of 12% of gross monthly revenues (payable on the first day of the month - based on estimated gross revenues). The term of the agreement is five years and shall automatically renew for additional five-year terms. The HMO may terminate the agreement upon 30 days' written notice if default of standards of performance continues 60 days after notice of such default.

Financial Requirements

The financial requirements for an HMO under s. Ins 9.04, Wis. Adm. Code, are as follows:

	Amount Required
1. Minimum capital or permanent surplus	Either: $750,000, if organized on or after July 1, 1989 or $200,000, if organized prior to July 1, 1989
2. Compulsory surplus	The greater of $750,000 or: If the percentage of covered liabilities to total liabilities is less than 90%, 6% of the premium earned in the previous 12 months; If the percentage of covered liabilities to total liabilities is at least 90%, 3% of the premium earned in the previous 12 months
3. Security surplus	The greater of: 140% of compulsory surplus reduced by 1% of compulsory surplus for each $33 million of additional premiums earned in excess of $10 million or 110% of compulsory surplus
4. Operating funds	Funds sufficient to finance any operating deficits in the business and to prevent impairment of the insurer's initial capital or permanent surplus or its compulsory surplus

Covered liabilities are those due to providers who are subject to statutory hold-harmless provisions.

Because the HMO writes Medicaid business only and Medicaid premium is not included in calculating the special deposit required by s. 609.98 Wis. Stat., the HMO is not required to have a special deposit with the State Treasurer.

Insolvency Protection for Policyholders

Under s. Ins 9.04 (6), Wis. Adm. Code, HMOs are required to provide continuation of coverage for its enrollees. These requirements are the following:

1. Enrollees hospitalized on the date of insolvency will be covered until discharged; and

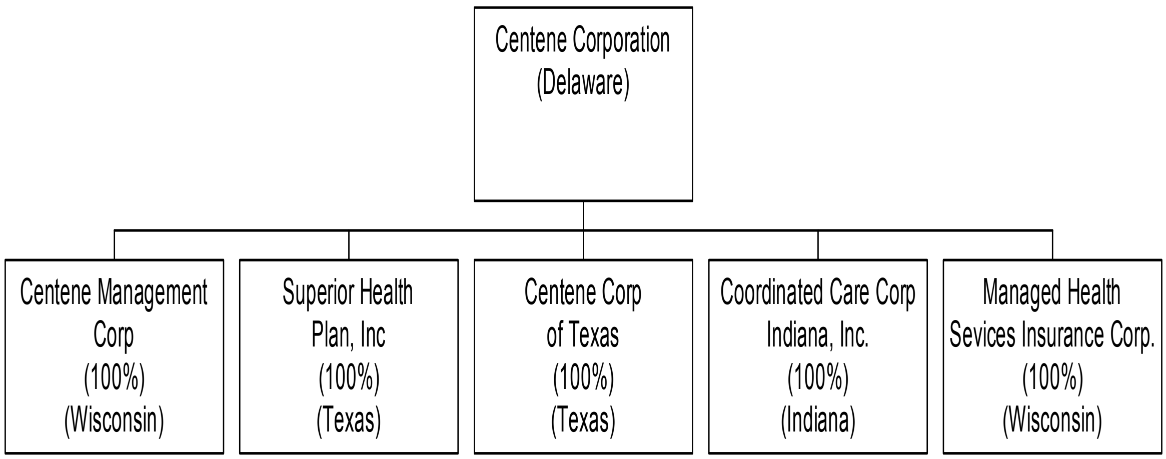
2. Enrollees will be entitled to similar, alternate coverage which does not contain any medical underwriting or preexisting limitation requirements.

Typically HMOs provide this coverage through reinsurance. However, MHSIC covers only Medicaid enrollees and MHSIC maintained that this coverage is provided automatically by Medicaid. This is discussed further in the section of this report captioned <u>"Current Examination Results</u>."

IV. AFFILIATED COMPANIES

The HMO is a member of a holding company system. Its ultimate parent is Centene Corporation. The organizational chart below depicts the relationships among the affiliates in the group. A brief description of the significant affiliates of the HMO follows the organizational chart.

Holding Company Chart
As of December 31, 2001



Centene Corporation

Centene Corporation, originally incorporated in 1993 as Coordinated Care Corporation, is a publicly held, for-profit company, headquartered in St. Louis, Missouri. It is the ultimate controlling person in the holding company system. It is a fully integrated government services managed care company with subsidiary health plans in Wisconsin, Indiana and Texas. As of December 31, 2001, the company's consolidated audited financial statement (000's omitted) reported assets of $131,366, liabilities of $67,277, and capital and surplus of $64,089. Operations for 2001 produced net income of $12,428 on revenues of $326,569.

Centene Management Corporation

Centene Management Corporation (CMC), originally incorporated in 1996 as Coordinated Care Medicaid Management Corporation, was created to provide management and administrative services to Centene Corporation's HMO subsidiaries. CMC, a wholly owned subsidiary of Centene Corporation, is a for-profit corporation that holds management agreements with Centene's subsidiaries and employs all staff, both at corporate headquarters and at the health plans. Licenses and certifications as required by individual state regulations are current. Specifically, in Wisconsin, CMC holds a license as an Employee Benefit Plan Administrator. As of December 31, 2001, the company's unaudited financial statement reported assets of $6,320,649, liabilities of $5,464,929, and capital of $855,720. Operations for 2001 produced net income of $4,145,437 on revenues of $31,712,091.

Superior HealthPlan, Inc.

Superior HealthPlan, Inc. is a Texas domiciled HMO with 54,944 members in 2001. As of December 31, 2001, the company audited financial statement reported assets of $20,347,551, liabilities of $17,737,010, and capital of $2,610,541. Operations for 2001 produced a net loss of $1,556,750 on revenues of $85,806,649.

Centene Corporation of Texas

As of December 31, 2001, Centene Corporation of Texas reported on their unaudited financial statement assets of ($306,210), liabilities of$355,006, and capital of ($661,216). Operations for 2001 produced a net loss of $77,759 on revenues of $10,405,775.

Coordinated Care Corporation Indiana, Inc

Coordinated Care Corporation Indiana, Inc. is an Indiana domiciled HMO with 65,890 members in 2001. Their audited financial statements reported assets of $28,073,641, liabilities of $20,439,471, and capital of $7,634,640. Operations for 2001 produced net income of $6,890,100 on revenues of $77,708,511.

V. REINSURANCE AND CORPORATE INSURANCE

The HMO has reinsurance coverage under the contracts outlined below:

Affiliated Contract:

Reinsurer:	Bankers Reserve Life Insurance Company of Wisconsin
Type:	Specific Excess of Loss Reinsurance
Effective date:	March 1, 2002
Retention:	Specific Deductible per Covered Person per Agreement Term: $125,000
Coverage:	90% of Covered Expenses excess of Specific Deductible
Premium:	$.92 per member per month
Termination:	January 1, 2003

Non-affiliated Contract:

Reinsurer:	Combined Insurance Company of America
Type:	Specific Excess of Loss Reinsurance
Effective date:	January 1, 2002
Retention:	Specific Deductible per Covered Person per Agreement Term: $150,000
Coverage:	90% of Covered Expenses excess of Specific Deductible if the complete claim is received by November 1, 2003. 50% of Covered Expenses excess of Specific Deductible if the complete claim is not received by November 1, 2003. Organ Transplant Services: 50% of Covered Expenses excess of the Specific Deductible if performed at a Non-Approved Transplant Facility.
Premium:	$.63 per member per month
Termination:	January 1, 2003

The above reinsurance contracts did not include the required insolvency provisions according to s. Ins. 52.03, Wis. Adm. Code. See Summary of Current Examination Results for more information.

In addition, the HMO is provided with corporate insurance coverage under the contracts listed below:

Type of Coverage	Policy Limits
Directors' and officers' liability	$5,000,000
Errors & Omissions	5,000,000
Property	2,555,000
General Liability	2,000,000
Umbrella Policy	2,000,000
Fidelity Bond	500,000

The above coverages were obtained through companies licensed in Wisconsin.

VI. FINANCIAL DATA

The following financial statements reflect the financial condition of the HMO as reported in the December 31, 2001, annual statement to the Commissioner of Insurance. Also included in this section are schedules that reflect the growth of the HMO for the period under examination. Adjustments made as a result of the examination are noted at the end of this section in the area captioned "Reconciliation of Net Worth per Examination."

Managed Health Services Insurance Corporation
Assets
As of December 31, 2001

	Assets	Nonadmitted Assets	Net Admitted Assets
Bonds	$12,433,649	$ 98,627	$12,335,022
Cash and short-term investments	16,676,889	2,586	16,674,303
Health care receivables	1,506,381		1,506,381
Amounts recoverable from reinsurers	999,443		999,443
Investment income due and accrued	215,687		215,687
Federal and foreign income tax recoverable and interest thereon	1,631,867	962,455	669,412
Aggregate write-ins for other than invested assets	1,439,747	1,157,283	282,464
Total assets	34,903,663	2,220,951	32,682,712

Managed Health Services Insurance Corporation
Liabilities and Net Worth
As of December 31, 2001

Claims unpaid	$24,231,145	
Accrued medical incentive pool and bonus payments	168,000	
General expenses due or accrued	1,919,839	
Amounts due to parent, subsidiaries and affiliates	30,926	
Total liabilities		26,349,910
Common capital stock	$ 750,000	
Gross paid in and contributed surplus	1,250,000	
Surplus notes	4,900,000	
Unassigned funds (surplus)	(567,198)	
Total capital and surplus		6,332,802
Total liabilities, capital and surplus		32,682,712

Managed Health Services Insurance Corporation
Statement of Revenue and Expenses
For the Year 2001

Net premium income		$122,426,555
Risk revenue		30,374,972
Total revenues		152,801,527
Medical and Hospital:		
Hospital/medical benefits	$ 88,906,900	
Other professional services	9,749,546	
Emergency room and out-of-area	9,588,278	
Aggregate write-ins for other medical and hospital	21,156,447	
Incentive pool and withhold adjustments	168,000	
Subtotal	129,569,171	
Less		
Net reinsurance recoveries	1,509,125	
Total medical and hospital	128,060,046	
Claims adjustment expenses	4,783,444	
General administrative expenses	16,275,260	
Total underwriting deductions		149,118,750
Net underwriting gain or (loss)		3,682,777
Net investment income earned	1,536,458	
Net realized capital gains or (losses)	199,288	
Net investment gains or (losses)		1,735,746
Net income or (loss) before federal income taxes		5,418,523
Federal and foreign income taxes incurred		1,807,890
Net income (loss)		3,610,633

Managed Health Services Insurance Corporation
Capital and Surplus Account
As of December 31, 2001

Capital and surplus prior reporting year		$4,547,810
Net income or (loss)	$3,610,633	
Net unrealized capital gains and losses	33,003	
Change in net deferred income tax	281,757	
Change in nonadmitted assets	(1,431,412)	
Change in surplus notes	(773,274)	
Cumulative effect of changes in accounting principles	64,285	
Net change in capital and surplus		1,784,992
Capital and surplus end of reporting year		6,332,802

Managed Health Services Insurance Corporation
Statement of Cash Flows
As of December 31, 2001

Cash from Operations			
Premiums and revenues collected net of reinsurance			$152,801,527
Claims and claims adjustment expenses			128,921,371
General administrative expenses paid			14,909,114
Cash from underwriting			8,971,042
Net investment income			1,569,328
Federal and foreign income taxes (paid) recovered			(1,067,175)
Net cash from operations			9,473,195
Cash from Investments			
Proceeds from investments sold, matured or repaid:			
Bonds		$ 6,010,828	
Cost of investments acquired (long-term only):			
Bonds		12,116,289	
Net cash from investments			(6,105,461)
Cash from Financing and Miscellaneous Sources			
Cash provided:			
Surplus notes, capital and surplus paid in	$ (773,274)		
Other cash provided	404,477		
Total		(368,797)	
Cash applied:			
Net transfers to affiliates	184,417		
Other applications	1,120,717		
Total		1,305,134	
Net cash from financing and miscellaneous sources			(1,673,931)
Net change in cash and short-term investments			1,693,803
Cash and short-term investments:			
Beginning of year			14,980,500
End of year			$16,674,303

Growth of Managed Health Services Insurance Corporation

Year	Assets	Liabilities	Capital and Surplus	Premium Earned	Medical Expenses Incurred	Net Income
2001	$32,682,712	$26,349,910	$6,332,802	$152,801,527	$129,569,171	$3,610,633
2000	25,046,686	20,498,874	4,547,812	74,135,449	62,735,277	993,214
1999	20,402,903	17,707,735	2,695,168	71,352,659	68,661,354	(4,416,246)
1998	19,090,509	15,287,695	3,802,814	75,560,303	68,337,243	(1,108,388)

Year	Profit Margin	Medical Expense Ratio	Administrative Expense Ratio	Change in Enrollment
2001	2.4%	84.8%	13.8%	109.1%
2000	1.3	84.6	13.5	23.4
1999	(6.2)	96.2	12.9	15.0
1998	(1.6)	90.4	13.0	7.3

Enrollment and Utilization

Year	Enrollment	Hospital Days/1,000	Average Length of Stay
2001	89,281	325.74	3.4
2000	42,692	329.63	3.3
1999	34,588	357.01	3.3
1998	44,986	295.98	3.1

Per Member Per Month Information

	2001	2000	Percentage Change
Medicaid Premium	$127.88	$128.05	(0.1)%
Expenses:			
Hospital/medical benefits	75.87	80.57	(5.8)
Other professional services	8.35	8.27	9.7
Emergency room and out-of-area	8.11	6.67	21.6
Other medical and hospital	17.34	13.80	25.7
Incentive pool and withhold adjustments	.18	.00	100.0
Less:			
Net reinsurance recoveries	1.34	.12	1016.7
Total medical and hospital	108.51	109.19	(0.6)
Claims adjustment expenses	5.00	.00	100.0
General administrative expenses	17.00	23.34	(27.2)
Total underwriting deductions	$130.51	$132.53	(1.5)

Since the prior examination, the company's assets and surplus have increased 71.2% and 66.5%, respectively. Premiums earned increased 102.2% due to the 98.5% increase in enrollment. The average length of stay has remained relatively the same for all years.

Reconciliation of Capital and Surplus per Examination

The following schedule is a reconciliation of capital and surplus between that reported by the HMO and as determined by this examination:

Capital and surplus December 31, 2001, per annual statement			$6,332,802
Examination Adjustments:	**Increase**	**Decrease**	
Miscellaneous Receivables		$(108,001)	
Net increase or (decrease)			(108,001)
Capital and surplus December 31, 2001, per examination			$6,224,801

VII. SUMMARY OF EXAMINATION RESULTS

Compliance with Prior Examination Report Recommendations

There were six specific comments and recommendations in the previous examination report. Comments and recommendations contained in the last examination report and actions taken by the HMO are as follows:

1. Management and Control—It is recommended that the company:

   - Explicitly document the approval of stockholder dividends in the board of director meeting minutes, pursuant to s. 180.0640, Wis. Stat.
   - Require all members of the board of directors, and all corporate officers, complete conflict of interest statements annually, and retain such statements in the company's files.
   - File biographical sketches with this office within 15 days of appointing any new officers and directors, pursuant to s. Ins 6.52, Wis. Adm. Code. It is further recommended that the company file biographical sketches for the officers/directors for whom biographical sketches were missing.
   - Report substantial changes to the company's business plan to our office at least 30 days prior to the effective date of the change, in accordance with s Ins. 3.50(6), Wis. Adm. Code.

   Action—Partial compliance, see Summary of Current Examination Results

2. Annual Statement—It is recommended that the company, in future annual statements, exclude the subcontract members from the membership figures on Report #4 – Enrollment and Utilization Table, and report operating results under this subcontract in the "Other" column on the Analysis of Operations By Lines of Business exhibit.

   Action—Compliance

3. Invested Assets—It is again recommended that all custodial agreements include safeguards and controls required by the NAIC Examiners Handbook.

   It is recommended that the company properly classify its security fund deposits in accordance with the NAIC Accounting Practices and Procedures Manual on future annual statements.

   Action—Compliance

4. Affiliated Balances—It is recommended that the company properly classify its intercompany payables in accordance with the NAIC Annual Statement Instructions on future annual statements.

   Action—Compliance

5. Other Assets—It is recommended that the company strive to more closely match estimated receivables with actual settlements, and, when in doubt, err on the side of conservatism.

   Action—Compliance

6. Net Worth—It is recommended that the company obtain approval from our office prior to entering into any surplus contribution agreements, in accordance with s. 611.33(2)(b), Wis. Stat. It is further recommended that the company obtain approval from our office prior to repayment of principal, or payment of interest on a surplus note, in accordance with s. 611.33(2)(d), Wis. Stat.

   Action—Non-Compliance, see Summary of Current Examination Results

7. Grievances—It is again recommended that the company:

   - Establish procedures to ensure that grievances are acknowledged within ten (10) days of receipt, pursuant to s. Ins 3.50 (10) (f), Wis. Adm. Code, and keep copies of all acknowledgments within the grievance files.
   - Resolve all grievances within 30 days, or notify the grievant in writing that MHSIC has not resolved the grievance, when resolution is expected, and the reason additional time is needed pursuant to s. Ins 3.50 (10) (c), Wis. Adm. Code.
   - Revise its provider agreements to specifically require providers to promptly forward all complaints and grievances to MHSIC for handling, pursuant to s. Ins 3.50 (10) (g) 2, Wis. Adm. Code.

   Action—Compliance

Summary of Current Examination Results

Management and Control

The prior examination recommended that the company file biographical sketches with this office within 15 days of appointing any new officers and directors, pursuant to s. Ins 6.52, Wis. Adm. Code. The company established a new board of directors in 2001, at the time of the examination, our office had not received biographical sketches for several of the board members. It is again recommended that the company file biographical sketches with this office within 15 days of appointing any new officers and directors pursuant to s. Ins 6.52, Wis. Adm. Code.

The prior examination also recommended that the company require all members of the board of directors and all corporate officers, to complete conflict of interest statements annually, and retain such statements in the company's files. The company had officers of the company fill out conflict of interest statements for 2002, however conflict of interest statements were not filled out for years prior to 2002 and several members of the board of directors have not filled out conflict of interest statements for any years under review. It is again recommended that the company require all members of the board of directors, corporate officers, and key employees complete conflict of interest statements annually, and retain such statements in the company's files.

Annual Statement

The examination's review of the 2001 annual statement revealed the company did not include the board of directors or vice presidents of the company on the jurat page of the annual statement. The board of directors was appointed in 2001 and there are individuals who are vice presidents but were not included on the jurat page. It is recommended that the company properly fill out the jurat page according to the NAIC Annual Statement Instructions.

Reinsurance Contracts

The examination's review of the reinsurance contract with Combined Insurance Company of America revealed that the agreement did not include the necessary insolvency provisions required by s. Ins. 52.03, Wis. Adm. Code. This regulation requires a clause to be included in the agreement that guarantees payment of the liability of the reinsurer without diminution because of the insolvency of the ceding company. It is recommended that the company amend its reinsurance contract with Combined Insurance Company of America to include the necessary insolvency provisions according to s. Ins. 52.03, Wis. Adm. Code.

Financial Requirements

As discussed previously, s. Ins 9.04 (6), Wis. Adm. Code, requires HMOs to either maintain compulsory surplus at the level required by s. Ins 51.80, Wis. Adm. Code, or provide for the following in the event of the HMO's insolvency:

1. Enrollees hospitalized on the date of insolvency will be covered until discharged; and

2. Enrollees will be entitled to similar, alternate coverage which does not contain any medical underwriting or preexisting limitation requirements.

Typically HMOs provide these insolvency protections through reinsurance. However, MHSIC covers only Medicaid enrollees and MHSIC maintains that this coverage is provided automatically by the Medicaid contract. It is recommended that the company implement a plan to come into compliance with s. Ins 9.04 (6), Wis. Adm. Code. The company has come into compliance with this requirement subsequent to the date of this examination report.

Crime Coverage

The company currently has crime coverage in the amount of $500,000. According to the criteria set by the NAIC Financial Examiners Handbook, this coverage should be between $800,000 - $900,000 based on its risk exposure. It is recommended that the company increase its crime coverage to a level that would comply with the criteria set by the NAIC Financial Examiners Handbook.

Bonds

In reviewing the annual statement, the examination disclosed several issues in regards to the company's bonds:

- United States Treasury bond with cusip number 91287-6J-6 was overstated by $500,000 and the Treasury bond with cusip number 91287-6T-4 was understated by $500,000.

- The company bought and sold securities within the same year and recorded these investments on Schedule D, Part 1 and Schedule D, Part 4. Investments that are bought and sold within the same year should be recorded on Schedule D, Part 5.

- The company combined several of their investments when recording them on Schedule D, Part 1, 3, and 4. These bonds should be listed individually with the appropriate effective rate of interest, market value, par value, etc.

- According to SSAP No. 26, Paragraph 7, bonds with a NAIC designation of 1 or 2 shall be reported at amortized cost and all other bonds shall be reported at the lower of amortized cost or fair value. The company has not been amortizing their bonds, which caused an overstatement of bonds on Schedule D, Part 1. Due to the immaterial difference between the market and statement value, no adjustment to surplus was deemed necessary.

- The company reported the market value of the bonds in column one of the assets page of the annual statement and included a non-admitted adjustment in column two to bring it to the reported statement value, which was incorrect as noted previously. The company should be reporting the statement value of the bonds only.

It is recommended that the company complete Schedule D of the annual statement, according to the NAIC Annual Statement Instructions.

According to the Purposes and Procedures Manual of the NAIC Securities Valuation Office, securities such as U.S. Treasury Bonds and FHLMC & FNMA bonds do not need to be reported to the SVO and these bonds would receive a SVO rating of provisionally exempt. The company did not report several of these types of the bonds to the SVO however they did give them a designation of 1. It is recommended that the company rate its bonds according to the Purposes and Procedures Manual of the NAIC Securities Valuation Office.

Unclaimed Property

The review of the bank reconciliations revealed that the HMO has not been setting up a liability for long outstanding checks or submitting an unclaimed property report for checks older than five years to the State Treasurer's Office. It is recommended that the company comply with ch. 177, Wis. Stat., as regards unclaimed funds, and that a liability for unclaimed funds be established in future statutory annual statements to account for all checks outstanding for over one year.

Investments

The examiner's review of the board of director minutes discovered the board does not approve the company's investments. The Investment Management Agreement between the company and Advisors Capital Management, Inc. (Advisors) gives Advisors the authority to make investment decisions according to the criteria set by the board, however the board does not formally approve these investments. According to 611.67(3), Wis. Stats., a company may delegate management authority to a person other than an officer, director or employee of the insurer if the person exercises the management authority according to the terms of the written contract between the insurer and the person, if the contract is filed and not disapproved by this office. The custodian agreement is not a management agreement nor does it delegate investment review and approval authority. It is recommended that the company establish procedures to have investment transactions formally approved by the board of directors.

Write-Ins for other than Invested Assets

The company reported a Miscellaneous Receivable in the amount of $108,001, which is a HIRSP overpayment to Network Health Plan (NHP). According to SSAP No. 4, assets that are not specifically identified as an admitted asset within the Accounting Practices and Procedures Manual shall be nonadmitted on the balance sheet. The above balance is to be repaid by NHP over a five-year term by offsetting it with the monthly fee. It is recommended that the company properly record assets and nonadmitted assets according to SSAP No. 4.

Net Worth

The prior examination recommended that the company obtain approval from OCI prior to entering into any surplus contribution agreements, in accordance with s. 611.33 (2) (b), Wis. Stats. The company issued two separate surplus notes to its parent company, Centene Corporation in March 1999 and June 1999. The company does not have any supporting documentation for these notes or prior approval from our office. It is again recommended that the company obtain approval from our office prior to entering into any surplus contribution agreements, in accordance with s. 611.33 (2) (b), Wis. Stat.

Compulsory Surplus Requirement

As noted in the section of this report captioned "Financial Requirements," HMOs are required to maintain minimum compulsory surplus. The HMO's calculation as of December 31, 2001, according to s. Ins 9.04, Wis. Adm. Code and modified for examination adjustments is as follows:

Assets	$32,682,712	
Less:		
Liabilities	26,349,910	
Examination adjustments	(108,001)	
Total		$6,224,801
Net premium earned	152,801,527	
Compulsory factor	3 %	
Compulsory surplus		4,584,046
Compulsory Excess		$1,640,755

VIII. CONCLUSION

Managed Health Services Insurance Corp. (MHSIC) is a for-profit, mixed model HMO serving 21 counties throughout Wisconsin. The company commenced business in 1990, and was acquired by its present parent, Centene Corporation, on September 8, 1993.

MHSIC's only line of business is coverage provided for Medical Assistance (Medicaid) and BadgerCare with 100% of its capitation and premium revenues coming from Wisconsin Title XIX Medical Assistance and BadgerCare Programs. The company's enrollees and premium earned increased by 109.1%, and 106.1% respectively from 2000 to 2001, due to the purchase of Humana Wisconsin Health Insurance Corporation's Medicaid/BagerCare line of business. MHSIC's 2001 annual statement reported assets of $32,682,712, liabilities of $26,349,910, and surplus of $6,332,802. As a result of the examination, $108,001 in outstanding receivables was nonadmitted bringing the company's surplus to $6,224,801. Operations for 2001 produced an underwriting gain of $3,682,777 and net income of $3,610,633. Overall premium has increased 119.3% in the past four years.

The company complied with five out of seven prior examination recommendations with two recommendations being repeated. This examination resulted in twelve recommendations and one adjustment to surplus due to the company recording a nonadmitted asset. Subsequent to the date of this examination, the company complied with the recommendations in regards to the filing of biographical sketches and filed an amendment to their reinsurance contract with Combined Insurance Company of America that contains the proper insolvency provisions according to s. Ins 52.03, Wis. Adm. Code.

IX. SUMMARY OF COMMENTS AND RECOMMENDATIONS

1. Page 25 - Management and Control—It is again recommended that the company file biographical sketches with this office within 15 days of appointing any new officers and directors pursuant to s. Ins 6.52, Wis. Adm. Code

2. Page 25 - Management and Control—It is again recommended that the company require all members of the board of directors, corporate officers, and key employees complete conflict of interest statements annually, and retain such statements in the company's files.

3. Page 25 - Annual Statement—It is recommended that the company properly fill out the jurat page according to the NAIC Annual Statement Instructions.

4. Page 26 - Reinsurance Contracts—It is recommended that the company amend their reinsurance contract with Combined Insurance Company of America to include the necessary insolvency provisions according to s. Ins 52.03, Wis. Adm. Code.

5. Page 26 - Financial Requirements—It is recommended that the company implement a plan to come into compliance with s. Ins 9.04, Wis. Adm. Code.

6. Page 26 - Crime Coverage—It is recommended that the company increase it's crime coverage to a level that would comply with the criteria set by the NAIC Financial Examiners Handbook.

7. Page 27 - Bonds—It is recommended that the company complete Schedule D of the annual statement according to the NAIC Annual Statement Instructions.

8. Page 27 - Bonds—It is recommended that the company rate its bonds according to the Purposes and Procedures Manual of the NAIC Securities Valuation Office.

9. Page 27 - Unclaimed Property—It is recommended that the company comply with ch. 177, Wis. Stat., as regards unclaimed funds, and that a liability for unclaimed funds be established in future statutory annual statements to account for all checks outstanding for over one year.

10. Page 28 - Investments—It is recommended that the company establish procedures to have investment transactions formally approved by the board of directors.

11. Page 28 - Write-Ins for other than Invested Assets—It is recommended that the company properly record assets and nonadmitted assets according to SSAP No. 4.

12. Page 29 - Net Worth—It is again recommended that the company obtain approval from our office prior to entering into any surplus contribution agreements, in accordance with s. 611.33 (2) (b), Wis. Stat.

X. ACKNOWLEDGMENT

The courtesy and cooperation extended during the course of the examination by the officers and employees of the HMO is acknowledged.

In addition to the undersigned, the following representatives of the Office of the Commissioner of Insurance, State of Wisconsin, participated in the examination:

Name	Title
Bridgot Quandt	Insurance Financial Examiner
Randy Milquet	Insurance Financial Examiner - Advanced

Respectfully submitted,

Sonja M. Dedrick
Examiner-in-Charge

XI. SUBSEQUENT EVENTS

The company submitted biographical sketches and 2002 conflict of interest statements to OCI on January 21, 2003 for the board of directors and officers. At the time of this report the HMO filed all biographical sketches and 2002 conflict of interest statements.

An amendment to the reinsurance contract with Combined Insurance Company of America was received by OCI on January 30, 2003. The amendment contains the necessary insolvency provisions according to s. Ins 52.03, Wis. Adm. Code.

An amendment to the reinsurance contract with Ace American Insurance Company was received by OCI on August 19, 2003. By agreement, the amendment contains the necessary insolvency protections required by s. Ins 9.04(6), Wis. Adm. Code.